45th Day 5/20/11

PRINTED: 04/13/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL537178	A. BUILDING _____ B. WING _____	04/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE BRIDGE OF GOODLETTSVILLE	3001 BUSINESS PARK CIRCLE GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 001	1200-08-25 Initial This Rule is not met as evidenced by: During the annual licensure survey completed on April 4, 2011, complaints #24456, #25325, #25541, #25547, #25603, #25851, #26288, and #26642 were investigated. Deficiencies were cited in relation to complaint #25325 and the licensure survey under 1200-8-25, Standards for Assisted Care Living Facilities.	D 001	The following is a summary of the Plan of Correction for Clare Bridge Goodlettsville. This Plan of Correction is in regards to the State Licensure Survey and a complaint investigation conducted on April 4th and 5th, 2011.This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanctions or fine. Rather, it is submitted a confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.	
D 831	1200-08-25-.08 (9)(a) Admissions, Discharges, and Transfers (9) An ACLF utilizing secured units shall provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents at its annual survey: (a) Documentation that an interdisciplinary team consisting of at least a physician, a social worker, a registered nurse, and a family member (or patient care advocate) has evaluated each secured resident prior to admittance to the unit; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the interdisciplinary team assessed residents prior to their admission to the facility for four residents (#7, #8, #9, #10) of thirteen residents reviewed. The findings included: Medical record review revealed Resident #7 was admitted to the facility on December 9, 2010, with diagnoses to include Dementia. Continued	D 831	D831 Starting, on April 4, 2011 and on going, all new admission will have signed documentation that an interdisciplinary team has evaluated the residents prior to or at admission. The Executive Director and Health and Wellness Director will monitor documentation for regulatory compliance.	4/4/11 ongoing per Sherry Patty, Asst. on 4/26/11 CAB

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wanda Palumbo TITLE: Executive Director (X6) DATE: 4/21/11

STATE FORM 6899 4CRD11 If continuation sheet 1 of 4

APR 25 2011

PRINTED: 04/13/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL537178	A. BUILDING _____ B. WING _____	04/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE BRIDGE OF GOODLETTSVILLE	3001 BUSINESS PARK CIRCLE GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 831	Continued From page 1 medical record review revealed no interdisciplinary assessment of the resident prior to admission to the facility to determine the resident's appropriateness for assisted care living facility. Medical record review revealed Resident #8 was admitted to the facility on December 3, 2010, with diagnoses to include Dementia and Hypertension. Continued medical record review revealed no interdisciplinary assessment of the resident prior to admission to the facility to determine the resident's appropriateness for assisted care living facility. Medical record review revealed Resident #9 was admitted to the facility on December 18, 2010, with diagnoses to include Dementia, Osteoarthritis, and Hypertension. Continued medical record review revealed no interdisciplinary assessment of the resident prior to admission to the facility to determine the resident's appropriateness for assisted care living facility. Medical record review revealed Resident #10 was admitted to the facility on November 20, 2010, with diagnoses to include Dementia, Osteoarthritis, and Diabetes Mellitus. Continued medical record review revealed no interdisciplinary assessment of the resident prior to admission to the facility to determine the resident's appropriateness for assisted care living facility. Interview on April 4, 2011 in the nurses's station with the Health and Wellness Director revealed residents # 7, 8, 9, 10, had not had an interdisciplinary assessment prior to admission.	D 831		

APR 25 2011

PRINTED: 04/13/
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL537178	A. BUILDING _____ B. WING _____	04/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE BRIDGE OF GOODLETTSVILLE	3001 BUSINESS PARK CIRCLE GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1218	Continued From page 2	D1218		
D1218	1200-08-25-.12 (3)(i) Resident Records (3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum: (i) Time and circumstances of discharge or transfer, including condition at discharge or transfer, or death; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure adequate documentation of resident transfer and subsequent discharge for one (#12) of thirteen residents reviewed. The findings included: Medical record review revealed Resident #12 was admitted to the facility on July 1, 2009, with diagnoses to include Dementia, Diabetes Mellitus, Hypertension, and Seizures. Continued medical record review revealed a discharge date of October 12, 2009 on the envelope containing the resident's record. Interview on April 4, 2011, at 4:45 p.m., in the nurses' station with the Health and Wellness Director revealed the resident's daughter came for a family meeting on October 12, 2009, and took the resident out. Continued interview revealed the facility was not aware the daughter had taken the resident to see the neurosurgeon who admitted the resident to the hospital. Further	D1218	D1218 the Health and Wellness Director/designee will audit all charts at discharge for disposition of resident's whereabouts, and documents, on the resident logs (nurse's notes) and will monitor for regulatory compliance.	4/4/11 ongoing per Sherry Petty, Asst. on 4/26/11 – AVG

APR 25 2011

PRINTED: 04/13/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL537178	A. BUILDING _____ B. WING _____	04/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE BRIDGE OF GOODLETTSVILLE	3001 BUSINESS PARK CIRCLE GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1218	Continued From page 3 interview with the Health and Wellness Director revealed the resident was transferred to another facility and subsequently expired. During continued interview the Health and Wellness Director confirmed there was no documentation of the resident's transfer to hospital and subsequent discharge from the facility. C/O 25325	D1218		

APR 25 2011

45th Day 5/20/11

PRINTED: 04/07/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL537178	A. BUILDING 01 - MAIN BUILDING B. WING _____	04/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE BRIDGE OF GOODLETTSVILLE	3001 BUSINESS PARK CIRCLE GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 916	1200-08-25-.09 (16) Building Standards (16)The licensed contractor shall ensure through the submission of plans and specifications that in each ACLF: (a) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms; (b) A minimum of eighty (80) square feet of bedroom space must be provided each resident. No bedroom shall have more than two (2) beds. Privacy screens or curtains must be provided and used when requested by the resident; (c) Living room and dining areas capable of accommodating all residents shall be provided, with a minimum of fifteen (15) square feet per resident per dining area; and (d) Each toilet, lavatory, bath or shower shall serve no more than six (6) persons. Grab bars and non-slip surfaces shall be installed at tubs and showers. This Rule is not met as evidenced by: Based on observations during the survey, it was determined the facility failed to maintain the heating, ventilation and the air-conditioning system as required. The finding include: On 4/5/11, at 10:45 a.m., observation within the 'A' hall, dietary and the office areas revealed the	D 916	D916 As of April 11, 2011 "A" hall, dietary and office area's grills were clean of all visual dust. The Maintenance Director/designee will continue to inspect community on weekly bases to monitor Building standard compliance. 4/11/11 per Sherry Patty, Asst., on 4/26/11 CVG	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Wanda Columbo TITLE Executive Director (X6) DATE 4/21/11

STATE FORM 6899 4CRD21 If continuation sheet 1 of 2

APR 25 2011

PRINTED: 04/07/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL537178	A. BUILDING 01 - MAIN BUILDING B. WING _____	04/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE BRIDGE OF GOODLETTSVILLE	3001 BUSINESS PARK CIRCLE GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 916	Continued From page 1 air return grilles were dirty. Tennessee Department of Health TDoH 1200-08-25-.09(16) National Fire Protection Association (NFPA) 101, 33.3.6.2.1 This finding was acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 4/5/11.	D 916		
D1034	1200-08-25-.10 (7) Life Safety (7) An ACLF shall not allow trash and other combustible waste to accumulate within and around the ACLF. It shall store trash in appropriate containers with tight-fitting lids. An ACLF shall furnish resident sleeping units with an UL approved trash container. This Rule is not met as evidenced by: Based on observations during the survey, it was determined the facility failed to provide Underwriters Laboratory (UL) approved trash containers in resident rooms as required. The findings include: On 4/5/11, at 9:45 a.m., observations within resident rooms A6; B2; B5; B9; C4 and C11 revealed the trash cans were not fire rated and UL approved. Tennessee Department of Health 1200-08-25-.10(7) This finding was acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 4/5/11	D1034	D1034 Trash containers will be replaced to a (UL) approved container by May 30th 2011. The Maintenance Director and the Executive Director /designee will continue to monitor regularly for compliance through out the community.	5/19/11 ongoing per Sherry Petty, Asst. Dir. 4/26/11 – NG

APR 25 2011